The impact of fundholding on prescribing budgets

David Whynes BPhil, MLitt
and Darrin Baines MSc

A report by the OHE reviews the impact of budgets on prescribing following the introduction of fundholding in 1990. Here, two of the report's authors examine the success of the fundholding scheme in controlling drug costs in general practice and propose that prescribing budgets should not be abandoned.

From the point of view of general practice, fundholding was the centre-piece of the devolved budgetary system introduced following the 1990 NHS Act. With the recent publication of the White Paper its days are now numbered. There is a certain irony in the turn of events, for it is only now that evidence for the success, or otherwise, of the fundholding experiment is accruing.

Influence on prescribing habits

Fundholding's supposed contribution to the creation of a 'two-tier' NHS has been at the centre of the public debate; for example, the apparent ability of fundholders' patients to obtain preferential waiting times for secondary care. However, to date, little public attention has been paid to how GPs' prescribing habits have been influenced by fundholding and to the imposition of prescribing budgets more generally.

During the 1980s, the real cost of medicines prescribed by general practitioners increased by more than 50 per cent per patient. In 1990, prescribing budgets – real for fundholders, and nominal for non-fundholders – were introduced in an attempt to exert a downward pressure on the growth of drugs expenditure. This, it was thought, would eliminate waste and release resources for other parts of the health service. In other words, in a cash-limited NHS, cost containment in prescribing was seen as a worthy objective in itself, and also beneficial both to the patient and the Treasury.

However, if cost containment was to be achieved it would, of course, be necessary for both fundholding and nonfundholding practices to stay within the budgets that were set for them.

The evidence

Since 1991, the Audit Commission and the National Audit Office, as well as a number of independent academic researchers, have been investigating the impact of budgets on prescribing. A report recently published by the OHE[1] has reviewed the findings of more than 30 empirical research studies, and has reached the following conclusions.

- Once they had joined the scheme, the prescribing costs of fundholders almost invariably rose more slowly than those of nonfundholders, who were subject only to nominal or indicative prescribing targets. Where local incentive schemes for nonfundholders were introduced, schemes which provided real rather than nominal savings for the practices concerned, constrained prescribing cost growth was also observable, in the same manner as for fundholders. As the economist would predict, therefore, the imposition of hard prescribing budgets involving real resources changed the nature of incentives, and GPs began to modify their prescribing behaviour in response.[2]

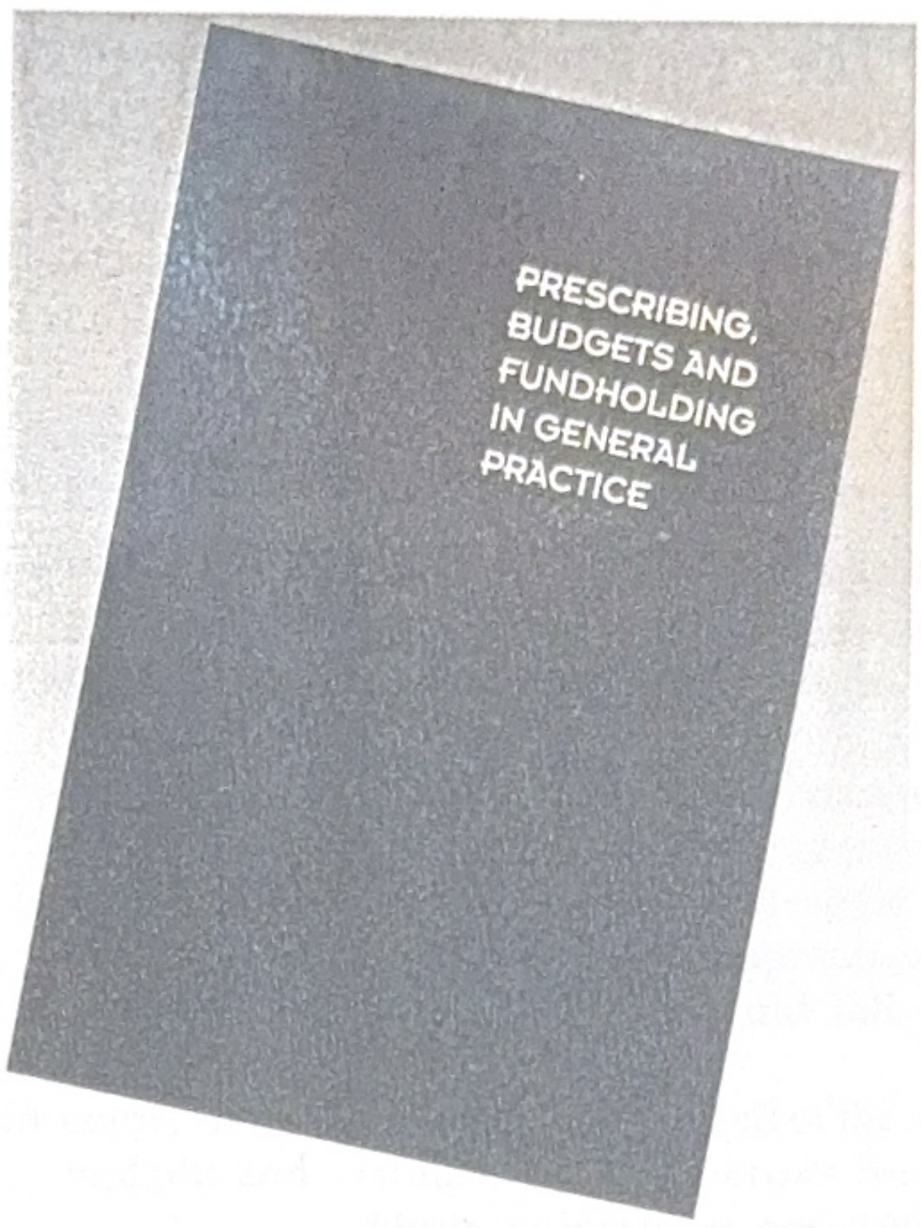

Figure 1. The recent OHE report examines the effect of prescribing budgets and incentives on prescribing costs in general practice

- As a result of differential cost control, fundholders have been more successful in meeting their prescribing budget targets than nonfundholders.
- The containment of prescribing cost growth was typically effected

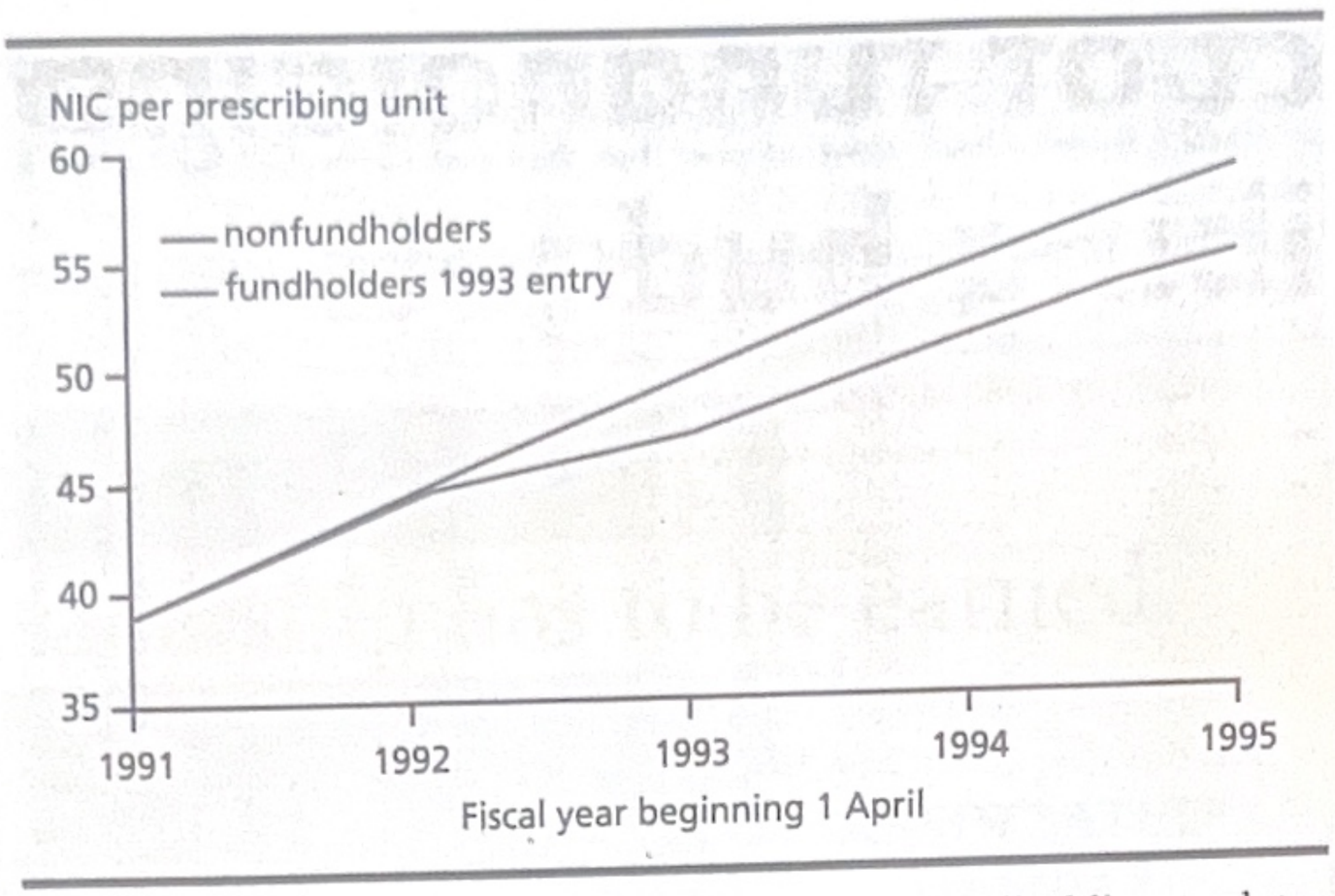

Figure 2. Effect of general practice fundholding on prescribing costs. Improvements in cost control in 1993 were short term: from 1994 growth reverted to the previous level (NIC = net ingredient cost)

by the use of one or more of a range of techniques already well known.[3] These included increased generic prescribing, stricter limitations on prescription volume (items per patient), the receipt of improved prescribing information such as PACT, and the use of practice-specific prescribing formularies.

- Practices with dispensing status were found to be higher-cost prescribers than those without such a status. However, the rate of growth in prescribing costs in dispensing practices also fell after the attainment of fundholding status.
- The improvements in cost control arising from the imposition of budgets and incentives were introduced rapidly by the practices concerned. For fundholders, the prescribing innovations appear to have been made in the one to two years immediately following entry to the scheme. In consequence, their impact on cost growth has essentially been short term.

Thereafter, prescribing cost growth reverts to the trend broadly experienced by all practices, as the scope for economies becomes exhausted. This pattern appears to have been repeated for all waves of fundholding to date. An example of this effect appears in Figure 2.

The future

The evidence reviewed suggests that any government concerned with the control of public spending on health care generally ought to think very carefully before abandoning prescribing budgets and incentives.

Fundholding budgets and prescribing incentives attempted to limit activities in general practice which had earlier been largely unconstrained. They offered the prospect of controlling cost escalation in an important area of NHS expenditure.

The key question is whether the new government wishes to continue the use of budgeting as a financial control mechanism for prescribing in general practice.

Incentive schemes

Even without fundholding, a prescribing incentive scheme in general practice could still be feasible. It would be possible to compress the existing prescribing schemes into one, by making the prescribing budget independent of practice status and allowing all GPs to retain savings on prescribing costs for discretionary use. However, if budgets are to remain important in resource allocation, further development work on the budget-setting mechanism is essential.

Allocation of budgets

Prescribing budgets are currently set on a weighted capitation basis, even though the weightings are known to be extremely imprecise indicators of both medical need and cost.[4]

Any allocation system driven by a budget will fail completely if the budget level is set incorrectly. If the budget is too tight, we risk jeopardising patient care, as the practice struggles to obtain unrealistic savings by limiting services; at the extreme, this struggle may be abandoned as impracticable, and the system would fall into disrepute.

At the opposite end of the spectrum, an overgenerous budget dilutes the incentives necessary for cost containment, and comes to represent, in effect, no budgetary constraint at all.

Conclusion

At present, our understanding of the impact of budgetary discipline on general practice prescribing is incomplete. Fundholders have responded to the incentives and have already rationalised prescribing, while those remaining outside the incentive schemes have yet to do so. The present situation is therefore unbalanced.

Let us add a caveat. While short-term cost-savings are evident from the imposition of budgets, we still do not know whether this has been put into effect at the expense, or independently, of patient care. The effects on morbidity and patient

satisfaction have remained largely unassessed. The response to a budget, after all, may simply be to moderate cost rather than to secure value for money in prescribing.

Does the 'two-tier' system exist?

If we can accept that use of prescribing budgets and incentives has indeed made fundholders more efficient in prescribing, then the 'two-tier' aspect of the NHS requires interpretation in this light.

Hard prescribing budgets have permitted the potentially efficient practices to actually become more efficient and left the inefficient behind. Savings from prescribing budgets will have been used in other areas of service development. If the NHS has become more inequitable, therefore, this is simply a consequence of increasing variations in efficiency, and the restoration of equity is not best served by requiring the efficient to be less efficient.

Incidentally, it should be borne in mind that 'two-tierism', if it indeed exists, must work both ways. Fundholders' patients might well have been on shorter hospital waiting lists than nonfundholders, but their prescribed medicines have been far more tightly controlled.

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David Whynes is reader in health economics at the University of Nottingham, and Darrin Baines is senior lecturer in health economics, Health Services Management Centre, at the University of Birmingham